



Getting the Biggest Bang for Your Buck: Reducing Readmissions While Providing Best Practices to Your COPD Patients

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Summary: COPD is the 3rd leading cause of death in the United States and a leading cause of disability. Healthcare costs related to COPD exceed forty billion per year, with hospitalization for acute exacerbations accounting for about 50% of the cost. In 2014, CMS announced the inclusion of COPD in the Hospital Readmissions Reduction Program (HRRP) to reduce costs and improve outcomes for the COPD patient population. Through readmission interviews and trending data, the primary causes of readmission were identified. Patient education on the disease process and disease management are essential to promote self-management after discharge from the hospital. Medication education with a focus on correct technique with inhaler devices and identification of rescue vs. control medications improves medication compliance. Smoking cessation, oxygen therapy, non-invasive ventilation, and pulmonary rehab are all essential elements of the treatment plan. Case management plays a vital role in identifying patients who are unable to afford their respiratory medications and providing the patient with prescription assistance resources. The inhaled medications are expensive, and the 2017 GOLD guidelines are recommending more aggressive management of patients with frequent exacerbations with triple therapy (LABA, LAMA, ICS). Inhalers to provide triple therapy average \$500-\$700 per month, making it difficult for many patients to be compliant with these prescriptions. Finally, smoking cessation, although difficult, is the only evidence-based intervention that will slow the progression of the disease. Implementation of a structured patient education program, targeting interventions at common causes on readmissions and providing transitional care following discharge, can reduce readmission rates for hospitals and frequency of exacerbations for COPD patients.

Nursing Implications:

- Patient education can empower the COPD patient to manage their disease well, reduce exacerbations, and improve their quality of life.
- Identification of hypercapnic respiratory failure and implementation of NPPV in the hospital and home can improve quality of life for the individual with COPD.
- Early and progressive mobility are vital to help the COPD patient maintain and restore their functional level.
- Transitional care after discharge can help to ensure the discharge plan of care is implemented by validating that the patient has filled all prescriptions and knows how to take them, that the patient has scheduled a follow-up visit, and that home health services have been initiated.

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**Key Takeaways:**

- Provide patient education on COPD and disease management during every hospitalization. Do not assume the patient is well informed just because they have had the diagnosis for years.
- Ask the patient if they can afford to fill the inhaled medication prescriptions. Work with the providers and case managers to ensure inhaled medications are prescribed that the patient will be able to afford.
- Be a cheerleader! Enthusiastically encourage your patient to be active and to wear the PAP device as prescribed. Celebrate smoking cessation behaviors.
- Stop the “blame and shame” associated with smoking and COPD.

Link: <https://library.amsn.org/amsn/sessions/3223/view>

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